Application for the Behavioral Add-Ons

Consumer_____ Date_____

Provider_____

Add-Ons Application for:
□ Home Support □ Community Support □ Work Support

Please provide a short description of the behavioral challenge, **or** highlight the relevant portion of the attached annual plan and note here the specific page(s) highlighted:

Please check off each item provided:

□ The annual plan is attached.

□ The behavioral plan or draft is attached.

□ The behavioral plan's author and credentials are identified:

□ The clinician monitoring the plan is identified:

□ The clinician has met the consumer and representative(s) of the treatment team.

□ The clinician has conferred with the guardian.

□ The clinician has agreed to monitor the plan and data quarterly.

□ The provider affirms that a summary or copy of each quarterly review will be provided to the Case Manager.
□ Agency Behavior Management Policy (Initial application only)

□ The provider affirms that all staff implementing the behavioral plan are trained on Consumer Rights and the Department's Behavioral Regulations.

□ The provider affirms that all staff implementing the behavioral plan are trained on its implementation prior to doing so.

Signature of CEO or designate_____ Date: _____

Signature of ISC indicating the packet is complete and represents the team's decision _____
Date:_____

October 4, 2007